

**COUNTY OF ORANGE, CA · HEALTH CARE AGENCY · PUBLIC HEALTH**  
**CONFIDENTIAL MORBIDITY REPORT**

NOTE: For STD, Hepatitis, or TB, complete appropriate section below.

DISEASE BEING REPORTED: _____		If applicable, specimen date: <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> <small>MONTH DAY YEAR</small>		Source: _____	
Patient's Last Name <table border="1" style="width: 100%; height: 20px;"></table>		Social Security Number <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> - <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> - <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table>		Ethnicity (√ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic / Non-Latino	
First Name and Middle Name <table border="1" style="width: 100%; height: 20px;"></table>		Birth Date <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>		Age <table border="1" style="width: 40px; height: 20px;"></table>	
Address: Number, Street <table border="1" style="width: 100%; height: 20px;"></table>		Apt./Unit Number <table border="1" style="width: 100%; height: 20px;"></table>		Race (√ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (√ one) <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other: _____	
City/Town <table border="1" style="width: 100%; height: 20px;"></table>		State <table border="1" style="width: 40px; height: 20px;"></table>		Zip Code <table border="1" style="width: 100%; height: 20px;"></table>	
Area Code    Home Telephone <table border="1" style="width: 40px; height: 20px;"></table> - <table border="1" style="width: 40px; height: 20px;"></table> - <table border="1" style="width: 40px; height: 20px;"></table>		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK	
Area Code    Work Telephone <table border="1" style="width: 40px; height: 20px;"></table> - <table border="1" style="width: 40px; height: 20px;"></table> - <table border="1" style="width: 40px; height: 20px;"></table>		Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other: _____		Estimated Delivery Date <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>	

  

DATE OF ONSET <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>	Reporting Health Care Provider _____ Reporting Health Care Facility _____ Address _____ City _____ State _____ Zip Code _____ Telephone Number (    )    Fax (    ) Submitted By _____ Date Submitted <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>	<b>REPORT TO:</b>  <b>Orange County Public Health</b>  <b>Fax: (714) 834-8196</b>  <b>Mail: P.O. Box 6128</b> <b>Santa Ana, CA 92706-0128</b>  <b>Phone: (714) 834-8180</b>
DATE DIAGNOSED <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>	DATE OF DEATH <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small>	

  

<b>SEXUALLY TRANSMITTED DISEASES (STD)</b> <b>Syphilis</b> <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Secondary <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Congenital <input type="checkbox"/> Latent (unknown duration) <input type="checkbox"/> Neurosyphilis  <b>Syphilis Test Results</b> <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/MHA: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____  <b>Gonorrhea</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____  <b>Chlamydia</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____  <input type="checkbox"/> PID (Unknown Etiology) <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis  <b>STD TREATMENT INFORMATION</b> <input type="checkbox"/> Treated (Drugs, Dosage, Route) Date Treatment Initiated <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small> <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____	<b>VIRAL HEPATITIS</b> <input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Hep C <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Hep D (Delta) <input type="checkbox"/> Other: _____  <b>Suspected Exposure Type</b> <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____
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Please send copies of the hepatitis serologies (required for diagnosis) and liver enzymes (if done).

  

<b>TUBERCULOSIS (TB)</b> <b>Status</b> <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected  <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Converter <input type="checkbox"/> Reactor  <b>Site(s)</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both	<b>Mantoux TB Skin Test</b> Date Performed <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small> Results _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not done <b>Chest X-ray</b> Date Performed <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small> <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory	<b>Bacteriology</b> Date Specimen Collected <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small> Source: _____ Smear: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Other test(s): _____ _____ _____
<b>TB TREATMENT INFORMATION</b> <input type="checkbox"/> Current Treatment <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____  Date Treatment Initiated <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"></table> <small>MONTH DAY YEAR</small> <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____		

**REMARKS**  
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